DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 02-02

2. STATE: ILLINOIS

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE: 1-1-02

5. TYPE OF PLAN MATERIAL *(Check One)*

☐ NEW STATE PLAN ☒ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☐ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:

7. FEDERAL BUDGET IMPACT
a. FFY 02 $ ($52,029,000)
b. FFY 03 $ ($125,115,000)

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Attachment 4.19A Pages 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 143, 144

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:

Attachment 4.19-A Pages 122, 123, 124, 125, 126, 127, 127A, 127B, 127C, 127D, 128, 128a, 129, 130, 131, 131A, 131B, 131C, 131D, 131E, 131F, 131G, 131H, 131I, 143

10. SUBJECT OF AMENDMENT:

INPATIENT

11. GOVERNOR'S REVIEW *(Check One)*

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED: Not submitted for review by prior approval.

12. SIGNATURE OF AGENCY OFFICIAL: Jackie Garner

13. TYPED NAME: Jackie Garner

14. TITLE: DIRECTOR

15. DATE SUBMITTED

16. RETURN TO:

ILLINOIS DEPARTMENT OF PUBLIC AID
201 SOUTH GRAND AVENUE, EAST
SPRINGFIELD, IL. 62763-0001
ATTENTION: John Rupcich

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: 2/8/02

18. DATE APPROVED: 4/5/02

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:

20. SIGNATURE OF REGIONAL OFFICIAL: Cheryl A. Harris

21. TYPED NAME: Cheryl A. Harris

22. TITLE: Associate Regional Administrator
Division of Medicaid and Children's Health

23. REMARKS:

RECEIVED
FEB 08 2002
DMCH - IL/IN/OH

FORM HCFA-179 (07-92) *Instructions on Back*

METHODS AND STANDARDS FOR ESTABLISHING INPATIENT RATES FOR HOSPITAL REIMBURSEMENT: MEDICAL ASSISTANCE-GRANT (MAG) AND MEDICAL ASSISTANCE-NO GRANT (MANG)

07/95 XV. Critical Hospital Adjustment Payments (CHAP)

10/99 Critical Hospital Adjustment Payments (CHAP) shall be made to all eligible hospitals excluding county-owned hospitals, as described in Chapter XVI A.1.a.i., unless otherwise noted in this Chapter XV, and hospitals organized under the University of Illinois Hospital Act, as described in Chapter XVI A.1.a.ii. for inpatient admissions occurring on or after July 1, 1998, in accordance with this Chapter. The provisions described in this Chapter will be effective through June 30, 2002.

10/99 A. Trauma Center Adjustments (TCA)
The Department shall make a trauma center adjustment (TCA) to Illinois hospitals recognized, as of the first day of July in the CHAP rate period, as a Level I or Level II trauma center by the Illinois Department of Public Health (IDPH), in accordance with the provisions of 1. through 3 of this Chapter ~~below~~.

07/95 1. Level I Trauma Center Adjustment (TCA).

10/99 a. Criteria. Illinois hospitals that, on the first day of July in the CHAP rate period are recognized as a Level I trauma center by the Illinois Department of Public Health, shall receive the Level I trauma center adjustment.

07/95 b. Adjustment. Illinois hospitals meeting the criteria specified in 1.a. of this Chapter ~~above~~ shall receive an adjustment as follows:

07/98 i. Hospitals with Medicaid trauma admissions equal to or greater than the mean Medicaid trauma admissions, for all hospitals qualifying under 1.a. of this Chapter ~~above~~, shall receive an adjustment of $21,365 per Medicaid trauma admission in the CHAP base period.

07/98 ii. Hospitals with Medicaid trauma admissions less than the mean Medicaid trauma admissions, for all hospitals qualifying under 1.a. of this Chapter ~~above~~, shall receive an adjustment of $14,165 per Medicaid trauma admission in the CHAP base period.

10/99 2. Level II Rural Trauma Center Adjustment (TCA). Illinois rural hospitals, as defined in Chapter XVI B.3., that, on the first day of July in the CHAP rate period, are recognized as a Level II trauma center by the Illinois Department of Public Health shall receive an adjustment of $11,565 per Medicaid trauma admission in the CHAP base period.

STATE OF ILLINOIS

METHODS AND STANDARDS FOR ESTABLISHING INPATIENT RATES FOR HOSPITAL REIMBURSEMENT: MEDICAL ASSISTANCE-GRANT (MAG) AND MEDICAL ASSISTANCE-NO GRANT (MANG)

10/99 3. Level II Urban Trauma Center Adjustment (TCA). Illinois urban hospitals, as described in Chapter XVI B.4., that, on the first day of July in the CHAP rate period, are recognized as Level II trauma centers by the Illinois Department of Public Health (IDPH) shall receive an adjustment of $11,565 per Medicaid trauma admission in the CHAP base period, provided that such hospital meets the criteria described in this Chapter ~~below~~:

07/95 a. The hospital is located in a county with no Level I trauma center; and

10/99 b. The hospital is located in a Health Professional Shortage Area ~~(HPSA) (42 CFR 5)~~, as of the first day of July in the CHAP rate period and has a Medicaid trauma admission percentage at or above the mean of the individual facility values determined in A.3.a. of this Chapter ~~above~~; or the hospital is not located in a ~~HPSA (42 CFR 5)~~ and has a Medicaid trauma admission percentage that is at least the mean plus one standard deviation of the individual facility values determined in subsection A.3.a. of this Chapter ~~above~~.

10/99 B. Rehabilitation Hospital Adjustment (RHA)

Illinois hospitals that, on the first day of July in the CHAP rate period, qualify as rehabilitation hospitals, as defined Section C.2. of Chapter II, and are accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF), shall receive a rehabilitation hospital adjustment in the CHAP rate period that consists of the following three components:

07/98 1. Treatment Component. All hospitals defined in Section B. of this Chapter ~~above~~, shall receive ~~$4,595~~ $3,886 per Medicaid Level I rehabilitation admission in the CHAP base period.

07/95 2. Facility Component. All hospitals defined in Section B. of this Chapter ~~above~~, shall receive a facility component that shall be based upon the number of Medicaid Level I rehabilitation admissions in the CHAP base period as follows:

07/97 a. Hospitals with fewer than 60 ~~90~~ Medicaid Level I rehabilitation admissions in the CHAP base period shall receive a facility component of ~~$250,000.00~~ $211,450 in the CHAP rate period.

STATE OF ILLINOIS

METHODS AND STANDARDS FOR ESTABLISHING INPATIENT RATES FOR HOSPITAL REIMBURSEMENT: MEDICAL ASSISTANCE-GRANT (MAG) AND MEDICAL ASSISTANCE-NO GRANT (MANG)

07/97 b. Hospitals with ~~90~~ 60 or more Medicaid Level I rehabilitation admissions in the CHAP base period shall receive a facility component of ~~$75,000~~ $486,335 in the CHAP rate period.

1/02 3. Health Professional Shortage Area Adjustment Component. Hospitals defined in Section B. ~~above~~ of this Chapter, that are located in an HPSA (~~42 CFR 5~~), as of the first day of July in the CHAP rate period, shall receive ~~$300.00~~ $254 per Medicaid Level I rehabilitation inpatient day in the CHAP base period.

07/99 C. Direct Hospital Adjustment (DHA) Criteria

1. Qualifying Criteria

Hospitals may qualify for the DHA under this subsection C. under the following categories:

a. Except for hospitals operated by the University of Illinois, children's hospitals, psychiatric hospitals, rehabilitation hospitals and long term stay hospitals, all other hospitals located in Health Service Area (HSA) 6 that either:

i. were eligible for Direct Hospital Adjustments under the CHAP program as of July 1, 1999, and had a Medicaid inpatient utilization rate (MIUR) equal to or greater than the statewide mean in Illinois on July 1, 1999;

ii. were eligible under the Supplemental Critical Hospital Adjustment Payment (SCHAP) program as of July 1, 1999, and had a MIUR equal to or greater than the statewide mean in Illinois on July 1, 1999; or

iii. were county-owned hospitals as defined in 89 Il. Adm. Code 148.25(b)(1)(A), and had a MIUR equal to or greater than the statewide mean in Illinois on July 1, 1999.

b. Illinois Hospitals located outside of HSA 6 that have a MIUR greater than 60 percent on July 1, 1999, and an average length of stay less than ten days. The following hospitals are excluded from qualifying from this criteria: children's hospitals; psychiatric hospitals; rehabilitation hospitals; and long term stay hospitals.

c. Children's hospitals, as defined under Section II.C.3, on July 1, 1999.

d. Illinois Teaching hospitals with more than 40 graduate medical education programs, on July 1, 1999, not qualifying in subsections C.1.a., b. or c. ~~above~~ of this Chapter.

STATE OF ILLINOIS

METHODS AND STANDARDS FOR ESTABLISHING INPATIENT RATES FOR HOSPITAL REIMBURSEMENT: MEDICAL ASSISTANCE-GRANT (MAG) AND MEDICAL ASSISTANCE-NO GRANT (MANG)

e. Except for hospitals operated by the University of Illinois, children's hospitals, psychiatric hospitals, rehabilitation hospitals, long term stay hospitals and hospitals qualifying in subsections (C)(1)(a),(b),(c) or (d) above, all other hospitals located in Illinois that had a MIUR equal to or greater than the mean plus one-half standard deviation on July 1, 1999, and provided more than 15,000 Total days.

01/02 f. Except for hospitals operated by the University of Illinois, children's hospitals, psychiatric hospitals, rehabilitation hospitals, long term stay hospitals and hospitals otherwise qualifying in subsections (C)(1)(a),(b),(c),(d) or (e), all other hospitals that had a ~~combined~~ MIUR greater than ~~30~~ 20.25 percent on July 1, 1999 and provided more than 20,000 total days.

g. Except for hospitals operated by the University of Illinois, children's hospitals, psychiatric hospitals, rehabilitation hospitals, long term stay hospitals and hospitals otherwise qualifying in subsections (C)(1)(a),(b),(c),(d),(e)or (f), all other hospitals that had a MIUR greater than 50 percent on July 1, 1999, and provided more than 10,000 total days.

h. Except for hospitals operated by the University of Illinois, children's hospitals, psychiatric hospitals, rehabilitation hospitals, long term stay hospitals and hospitals otherwise qualifying in subsections (C)(1)(a),(b),(c),(d),(e),(f) or (g), all other hospitals that had a MIUR greater than 40 percent on July 1, 1999, and provided more than 7,500 total days and provided obstetrical care as of July 1, 2001.

01/02 D. DHA Rates and Payments

1. For hospitals qualifying under subsection C.1.a. above, the DHA rates are as follows:

a. Hospitals that have a Combined MIUR that is equal to or greater than the Statewide mean Combined MIUR, but less than one standard deviation above the Statewide mean Combined MIUR, will receive ~~$75~~ $63 per day for hospitals that do not provide obstetrical care and ~~$115~~ $97 per day for hospitals that do provide obstetrical care.

b. Hospitals that have a Combined MIUR that is equal to or greater than one standard deviation above the Statewide mean Combined MIUR, but less than one and one-half standard deviations above the Statewide mean Combined MIUR, will receive ~~$115~~ $97 per day for hospitals that do not provide obstetrical care and ~~$155~~ $ 131 per day for hospitals that do provide obstetrical care.

STATE OF ILLINOIS

METHODS AND STANDARDS FOR ESTABLISHING INPATIENT RATES FOR HOSPITAL REIMBURSEMENT: MEDICAL ASSISTANCE-GRANT (MAG) AND MEDICAL ASSISTANCE-NO GRANT (MANG)

c. Hospitals that have a Combined MIUR that is equal to or greater than one and one-half standard deviations above the Statewide mean Combined MIUR, but less than two standard deviations above the Statewide mean Combined MIUR, will receive ~~$135~~ $114 per day for hospitals that do not provide obstetrical care and ~~$175~~ $148 per day for hospitals that do provide obstetrical care.

01/02 d. Hospitals that have a Combined MIUR that is equal to or greater than two standard deviations above the Statewide mean Combined MIUR will receive ~~$155~~ $131 per day for hospitals that do not provide obstetrical care and ~~$195~~ $165 per day for hospitals that do provide obstetrical care.

01/02 2. Hospitals qualifying under subsection C.1.a. ~~above;~~ of this Chapter will also receive the following rates:

a. County owned hospitals as defined in Section C.8 of Chapter II, with more than 30,000 Total days will have their rate increased by $455 per day.

b. Hospitals that are not county owned with more than 30,000 total days will have their rate increased by ~~$345~~ $292 per day.

c. Hospitals with more than 80,000 Total days will have their rate increased by an additional ~~$410~~ $434 per day.

d. Hospitals with more than 4,500 Obstetrical days will have their rate increased by ~~$110~~ $93 per day.

e. Hospitals with more than 5,500 Obstetrical days will have their rate increased by an additional ~~$185~~ $ 202 per day.

f. Hospitals with an MIUR rate greater than 74 percent will have their rate increased by ~~$160~~ $135 per day.

g. Hospitals with an average length of stay less than 3.9 days will have their rate increased by ~~$45~~ $38 per day.

h. Hospitals with a MUIR greater than the statewide mean plus one standard deviation that are designated a Perinatal Level 2 Center and have one or more obstetrical graduate medical education programs as of July 1, 1999, will have their rate increased by ~~$90~~ $ 76 per day.

i. Hospitals receiving payments under subsection (D)(1)(b) that have an average length of stay less than 4 days will have their rate increased by ~~$45~~ $38 per day.

j. Hospitals receiving payments under subsection(D)(1) that have a MIUR greater than 60 percent will have their rate increased by ~~$220~~ $186 per day.

k. Hospitals receiving payments under subsection (D)(1)(d) that have a Medicaid inpatient utilization rate greater than 70 percent and have more than 20,000 days will have their rate increased by ~~$5~~ $4 per day.

STATE OF ILLINOIS

METHODS AND STANDARDS FOR ESTABLISHING INPATIENT RATES FOR HOSPITAL REIMBURSEMENT: MEDICAL ASSISTANCE-GRANT (MAG) AND MEDICAL ASSISTANCE-NO GRANT (MANG)

3. Hospitals qualifying under subsection C.1.b. ~~above~~ of this Chapter will receive the following rates:
   a. Qualifying hospitals will receive a rate of ~~$330~~ $279 per day.
   b. Qualifying hospitals with the more than 1,500 Obstetrical days will have their rate increased by ~~$225~~ $190 per day.
4. Hospitals qualifying under subsection C.1.c. ~~above~~ of this Chapter will receive the following rates:
   a. Hospitals will receive a rate of ~~$30~~ $25 per day.
   b. Hospitals located in Illinois and outside of HSA 6, that have a Medicaid inpatient utilization rate greater than 60 percent, will have their rate increased by ~~$60~~ $51 per day.
   c. Hospitals located in Illinois and inside HSA 6, that have a Medicaid inpatient utilization rate greater than 80 percent, will have their rate increased by ~~$430~~ $364 per day.
   d. Hospitals that are not located in Illinois that have a Medicaid inpatient utilization rate greater than 45 percent will have their rate increased by ~~$35~~ $30 per day.
   e. Hospitals with more than 3,200 Total admissions will have their rate increased by ~~$270~~ $228 per day.
5. Hospitals qualifying under subsection C.1.d. of this Section will receive the following rates:
   a. Hospitals will receive a rate of ~~$45~~ $38 per day.
   b. Hospitals with a MIUR between 18 percent and 19.75 percent will have their rate increased by an additional ~~$15~~ $13 per day.
   c. Hospitals with a MIUR equal to or greater than 19.75 percent will have their rate increased by an additional ~~$145~~ $31 per day.
   d. Hospitals with a combined MIUR that is equal to or greater than 35 percent will have their rates increased by an additional $83 per day.
6. Hospitals qualifying under subsection C1.e above will receive ~~$205~~ $173 per day.
7. Hospitals qualifying under subsection C.1.f. of this Section will receive a rate of ~~$65~~ $135 per day.
8. Hospitals qualifying under subsection C.1.g. of this Section will receive a rate of ~~$45~~ $38 per day.
9. Hospitals qualifying under subsection C.1.h. of this Section will receive a rate of ~~$60~~ $51 per day.
10. Hospitals qualifying under subsection C.1.a.iii. above will have their rates multiplied by a factor of two.
11. Payments under this subsection D will be made at least quarterly, beginning with the quarter ending December 31, 1999.
    a. Payment rates will be multiplied by the Total days.

STATE OF ILLINOIS

METHODS AND STANDARDS FOR ESTABLISHING INPATIENT RATES FOR HOSPITAL REIMBURSEMENT: MEDICAL ASSISTANCE-GRANT (MAG) AND MEDICAL ASSISTANCE-NO GRANT (MANG)

~~b. Total Payment Adjustments~~

~~i. For the CHAP rate period occurring in State fiscal year 20002002, total payments will equal the methodologies described above, less the amount the hospital received under DHA and SCHAP for the quarter beginning July 1, 1999. 2001. For hospitals not qualifying for CHAP, DHA and SCHAP payments for the quarter ending September 30, 1999, 2001, total payments will equal the methodologies described above.~~

~~ii For CHAP rate periods occurring after State fiscal year 2000, 2002 total payments will equal the methodologies described above.~~

iii. Payments under this subsection ~~C~~ D that are made to disproportionate share hospitals in accordance with Chapter VI.C.7 will be considered to be disproportionate share payments, except for payments made to hospitals as defined in Chapter XIII.

E. Rural Critical Hospital Adjustment Payments (RCHAP)

Rural Critical Hospital Adjustment Payments (RCHAP) shall be made to rural hospitals as defined in Chapter XVI(B(3)) for certain inpatient admissions. The hospital qualifying under this subsection that has the highest number of Medicaid obstetrical care admissions during the CHAP base period shall receive ~~$400,000~~ $338,320 per year. The Department shall also make a RCHAP adjustment payment to hospitals qualifying under this subsection at a rate that is the greater of:

1. the product of ~~$1490~~ $1260 multiplied by the number of RCHAP Obstetrical Care Admissions in the CHAP base period, or
2. the product of ~~$150~~ $127 multiplied by the number of RCHAP General Care Admissions in the CHAP base period.

F. ~~Each eligible hospital's critical hospital adjustment payment for the CHAP rate period shall equal the sum of the amounts described in A., B., D and E. above. The critical hospital adjustment payments shall be paid to eligible hospitals at least quarterly~~. Total CHAP Payment Adjustments - For the remainder of the CHAP rate period occurring in State fiscal year 2002, each eligible hospital's critical hospital adjustment payment for the programs described in sections A, B, C and E of this Chapter, shall equal the result of the following calculation:

1. The total payments resulting from payment methodologies in effect on January 1, 2002, will be reduced by the total payments calculated from the payment methodologies that were in effect on December 31, 2001.
2. The difference from section (1) above will be divided by two and added to the total payments calculated from the payment methodologies that were in effect on December 31, 2001.

APR 0 5 2002

STATE OF ILLINOIS
METHODS AND STANDARDS FOR ESTABLISHING INPATIENT RATES FOR HOSPITAL REIMBURSEMENT: MEDICAL ASSISTANCE-GRANT (MAG) AND MEDICAL ASSISTANCE-NO GRANT (MANG)

~~a. Hospitals qualifying under the criteria described in I.1.b. above shall receive the DHA payment rate of $30 multiplied by the sum of the following days from the 1995 CHAP base period: total Medicaid days, Medcaid physchiatric days, Medicaid rehabilitation days, Medicaid obstetrical admissions less their Medicaid zero-paid days.~~

~~b. Hospitals that are eligible for DHA payments that have an affiliated Children's hospital shall receive additional payments in the following amounts:~~

~~i. If the hospital qualifies for DHA payments only under subsection C.2.b., it shall receive an additional payment of $69,000.~~

~~ii. If the hospital qualifies for DHA payments under both subsections C.2.b. and C.2.c., than it shall receive an additional payment of $124,760.~~

~~06/98 IJ. Critical Hospital Adjustment Payment Definitions. The definitions of terms used with reference to calculation of the CHAP required by this Section are as follows:~~

TN # 02-02
SUPERSEDES
TN # 98-07

APPROVAL DATE APR 05 2002 EFFECTIVE DATE 1-1-02

STATE OF ILLINOIS

METHODS AND STANDARDS FOR ESTABLISHING INPATIENT RATES FOR HOSPITAL REIMBURSEMENT: MEDICAL ASSISTANCE-GRANT (MAG) AND MEDICAL ASSISTANCE-NO GRANT (MANG)

3. The result of the calculation in subsection (2) above will be reduced by the actual payments each hospital already received for the period beginning July 1, 2001, and ending December 31, 2001, to produce the total payments for the remainder of State fiscal year 2002.
4. The critical hospital adjustment payments shall be paid at least quarterly.

G. Critical Hospital Adjustment Limitations. Hospitals that qualify for trauma center adjustments under Section A. above shall not be eligible for the total trauma center adjustment if, during the CHAP rate period, the hospital is no longer recognized by the Illinois Department of Public Health as a Level I trauma center as required for the adjustment described in A.1. above, or a Level II trauma center as required for the adjustment described in A.2. or A.3. of this Chapter ~~above~~. In these instances, the adjustments calculated shall be pro-rated, as applicable, based upon the date that such recognition ceased.

H. Critical Hospital Adjustment Payment Definitions

07/95

1. "CHAP base period" means State Fiscal Year 1994, for CHAP payments calculated for the July 1, 1995, CHAP rate period, State Fiscal Year 1995 for CHAP payments calculated for the July 1, 1996, CHAP rate period, etc.
2. "CHAP rate period" means, beginning July 1, 1995, the 12 month period beginning on July 1 of the year and ending June 30 of the following year.
3. "Combined MIUR" means the sum of Medicaid Inpatient Utilization Rate (MIUR) as of July 1, 1999, plus the Medicaid obstetrical inpatient utilization rate, as of July 1, 1999, both of which are defined in Chapter VI.C.8.
4. "Medicaid general care admission" means hospital inpatient admissions which were subsequently adjudicated by the Department through the last day of June preceding the CHAP rate period and contained within the Department's paid claims data base, for recipients of medical assistance under Title XIX of the Social Security Act, excluding admissions for normal newborns, Medicare/Medicaid crossover admissions, psychiatric and rehabilitation admissions.
5. "Medicaid Level I rehabilitation admissions" means those claims billed as Level I admissions which were subsequently adjudicated by the Department through the last day of June preceding the CHAP rate period and contained within the Department's paid claims data base, with an occurrence code of 63 when applicable and an ICD-9-CM principal diagnosis code of: 054.3, 310.1 through 310.2, 320.1, 336.0 through 336.9, 344.0 through 344.2, 344.8 through 344.9, 348.1, 801.30, 803.10, 803.84, 806.0 through 806.19, 806.20 through 806.24, 806.26, 806.29 through 806.34, 806.36, 806.4 through 806.5, 851.06, 851.80, 853.05, 854.0 through 854.04, 854.06, 854.1 through 854.14, 854.16, 854.19, 905.0, 907.0, 907.2, 952.0 through 952.09, 952.10 through 952.16, 952.2, and V57.0 through V57.89, excluding admissions for normal newborns.

STATE OF ILLINOIS

METHODS AND STANDARDS FOR ESTABLISHING INPATIENT RATES FOR HOSPITAL REIMBURSEMENT: MEDICAL ASSISTANCE-GRANT (MAG) AND MEDICAL ASSISTANCE-NO GRANT (MANG)

6. "Medicaid Level I rehabilitation inpatient day" means the days associated with the claims defined in subsection (H)(5) above.

7. "Medicaid obstetrical care admission" means hospital inpatient admissions which were subsequently adjudicated by the Department through the last day of June preceding the CHAP rate period and contained within the Department's paid claims data base, for recipients of medical assistance under Title XIX of Social Security Act, with a Diagnosis Related Group (DRG) of 370 through 375 ~~an ICD-9-CM principal diagnosis code of 640.0 through 648.9 with a 5th digit of 1 or 2; 650; 651.0 through 659.9 with a 5th digit of 1, 2, 3, or 4; 660.0 through 669.9 with a 5th digit of 1, 2, 3, or 4; 670.0 through 676.9 with a 5th digit of 1 or 2; or V27 through V27.9; or V30 through V39.9; or any ICD-9-CM principal diagnosis code that is accompanied with a surgery procedure code between 72 and 75.99~~; and specifically excludes Medicare/Medicaid crossover claims.

8. "Medicaid trauma admission" means those claims billed as admissions which were subsequently adjudicated by the Department through the last day of June preceding the CHAP rate period and contained within the Department's paid claims data base, with an ICD-9-CM principal diagnosis code of: 800.0 through 800.99, 801.0 through 801.99, 802.0 through 802.99, 803.0 through 803.99, 804.0 through 804.99, 805.0 through 805.98, 806.0 through 806.99, 807.0 through 807.69, 808.0 through 808.9, 809.0 through 809.1, 828.0 through 828.1, 839.0 through 839.3, 839.7 through 839.9, 850.0 through 850.9, 851.0 through 851.99, 852.0 through 852.59, 853.0 through 853.19, 854.0 through 854.19, 860.0 through 860.5, 861.0 through 861.32, 862.8, 863.0 through 863.99, 864.0 through 864.19, 865.0 through 865.19, 866.0 through 866.13, 867.0 through 867.9, 868.0 through 868.19, 869.0 through 869.1, 887.0 through 887.7, 896.0 through 896.3, 897.0 through 897.7, 900.0 through 900.9, 902.0 through 904.9, 925, 926.8, 929.0 through 929.99, 958.4, 958.5, 990 through 994.99. For those hospitals recognized as Level I trauma centers solely for pediatric trauma cases, Medicaid trauma admissions are only calculated for the claims billed as admissions, excluding admissions for normal newborns, which were subsequently adjudicated by the Department through the last day of June preceding the CHAP rate period and contained within the Department's paid claims data base, with ICD-9-CM diagnoses within the above ranges for children under the age of 18 excluding admissions for normal newborns.

9. "Medicaid trauma admission percentage" means a fraction, the numerator of which is the hospital's Medicaid trauma admissions and the denominator of which is the total Medicaid trauma admissions in a given 12 month period for all level II urban trauma centers.

STATE OF ILLINOIS
METHODS AND STANDARDS FOR ESTABLISHING INPATIENT RATES FOR HOSPITAL REIMBURSEMENT: MEDICAL ASSISTANCE-GRANT (MAG) AND MEDICAL ASSISTANCE-NO GRANT (MANG)

10. "RCHAP General Care Admission" means Medicaid General Care Admissions, as defined in subsection H.4. above, less RCHAP Obstetrical Care Admissions, occurring in the CHAP base period.

11. "RCHAP Obstetrical Care Admissions" means Medicaid Obstetrical Care Admissions, as defined in subsection H. 7 above, with a Diagnosis Related Group (DRG) of 370 through 375, occurring in the CHAP base period.

12. "Total admissions" means total paid admissions contained in the Department's paid claims database, including obstetrical admissions multiplied by two and excluding Medicare crossover admissions, for dates of service occurring in State fiscal year 1998 and adjudicated through June 30, 1999.

13. "Total days" means total paid days contained in the Department's paid claims database, including obstetrical days multiplied by two and excluding Medicare crossover days, for dates of service occurring in State fiscal year 1998 and adjudicated through June 30, 1999.

14. "Total obstetrical days" means hospital inpatient days for dates of service occurring in State fiscal year 1998 and adjudicated through June 30, 1999, with an ICD-9-CM principal diagnosis code of 640.0 through 648.9 with a 5th digit of 1 or 2; 650; 651.0 through 659.9 with a 5th digit of 1, 2, 3, or 4; 660.0 through 669.9 with a 5th digit of 1, 2, 3, or 4; 670.0 through 676.9 with a 5th digit of 1 or 2; or V27 through V27.9; or V30 through V39.9; or any ICD-9-CM principal diagnosis code that is accompanied with a surgery procedure code between 72 and 75.99; and specifically excludes Medicare/Medicaid crossover claims.

STATE OF ILLINOIS

METHODS AND STANDARDS FOR ESTABLISHING INPATIENT RATES FOR HOSPITAL REIMBURSEMENT: MEDICAL ASSISTANCE-GRANT (MAG) AND MEDICAL ASSISTANCE-NO GRANT (MANG)

~~04/01 k. Tertiary Care Payments~~

~~Tertiary Care Adjustment Payments shall be made to all eligible hospitals, excluding county-owned hospitals, as described in Chapter II.C.8. and hospitals organized under the University of Illinois Hospital Act, as described in Chapter II.C.8 for inpatient admissions occurring on or after April 1, 2001, in accordance with this Section.~~

~~1. Definitions. The definitions of terms used with reference to calculation of payments under this Section are as follows:~~

~~a. "Base Period Claims" means claims for inpatient hospital services with dates of service occurring in the Tertiary Adjustment Base Period that were subsequently adjudicated by the Department through December 31, 1999. For a general care hospital that includes a facility devoted exclusively to caring for children and that was separately licensed as a hospital by a municipality before September 30, 1998, Base Period Claims for services that may, in Chapter II.C.3.a., be billed by a children's hospital shall be attributed exclusively to the children's facility. Base Period Claims shall exclude the following types:~~

~~i. Claims for which Medicare was liable in part or in full ("cross-over" claims);~~
~~ii. Claims for transplantation services that were paid by the Department via form C-13, Invoice Voucher; and~~
~~iii. Claims for services billed under categories of service 037 and 038 (exceptional care services)~~

~~b. "Case Mix Index" (CMI), for all hospitals qualifying under this subpart K, means the sum of all Diagnosis Related Grouping (DRG) (see Chapter I.F.) weighting factors for Base Period Claims divided by the total number of claims included in the sum, but excluding claims:~~

STATE OF ILLINOIS

METHODS AND STANDARDS FOR ESTABLISHING INPATIENT RATES FOR HOSPITAL REIMBURSEMENT: MEDICAL ASSISTANCE-GRANT (MAG). AND MEDICAL ASSISTANCE-NO GRANT (MANG).

~~i. Reimbursed under a per diem rate methodology; and~~
~~ii. For Delivery or Newborn Care.~~

~~c. Case Mix Adjustment Factor" (CMAF) means the following:~~

~~i. For qualifying hospitals located in Illinois that, for Base Period Claims, had a CMI that is greater than the mean:~~
~~A. CMI of all cost-reporting hospitals, but less than that mean plus a one standard deviation above the mean, the CMAF shall be equal to 0.040;~~
~~B. CMI plus one standard deviation above the mean of all cost reporting hospitals, but less than that mean plus two standard deviations above the mean, the CMAF shall be equal to 0.250;~~
~~C. CMI plus two standard deviations above the mean of all cost reporting hospitals, the CMAF shall be equal to 0.300.~~
~~ii. For qualifying hospitals located outside of Illinois that, for Base Period Claims, had a CMI that is greater than the mean:~~
~~A. CMI of all out-of-state cost reporting hospitals, but less than that mean plus a one standard deviation above the mean, the CMAF shall be equal to 0.020;~~
~~B. CMI plus one standard deviation above the mean of all out-of-state cost reporting hospitals, but less than that mean plus two standard deviations above the mean, the CMAF shall be equal to 0.125;~~

STATE OF ILLINOIS

METHODS AND STANDARDS FOR ESTABLISHING INPATIENT RATES FOR HOSPITAL REIMBURSEMENT: MEDICAL ASSISTANCE-GRANT (MAG). AND MEDICAL ASSISTANCE-NO GRANT (MANG).

C. CMI plus two standard deviations above the mean of all out-of-state cost reporting hospitals, the CMAF shall be equal to 0.150.

d. "Delivery or Newborn Care" means inpatient hospital care, the claim for which was assigned by the Department to DRGs 370 through 375, 385 through 387, 389, 391 and 985 through 989.

e. "Tertiary Adjustment Base Period" means calendar year 1998.

f. "Tertiary Care Adjustment Rate Period" means, for fiscal year 2001, the three-month period beginning April 1, 2001, and for each subsequent fiscal year, the twelve-month period beginning July 1.

2. Case Mix Adjustment - The Department shall make a Case Mix Adjustment to certain hospitals, as defined in this subsection (2).

a. Qualifying Hospital. A hospital meeting all of the following criteria shall qualify for this payment:

i. A hospital that had 100 or more Qualified Admissions; and

ii. For a hospital located:

A. in Illinois, has a CMI greater than or equal to the mean CMI for Illinois hospitals; or

B. outside of Illinois, has a CMI greater than or equal to the mean CMI for out-of-state cost-reporting hospitals.

APR 05 2002

TN # 02-02 APPROVAL DATE _____ EFFECTIVE DATE 01-01-02
SUPERSEDES
TN # 01-01

STATE OF ILLINOIS

METHODS AND STANDARDS FOR ESTABLISHING INPATIENT RATES FOR HOSPITAL REIMBURSEMENT: MEDICAL ASSISTANCE-GRANT (MAG). AND MEDICAL ASSISTANCE-NO GRANT (MANG).

~~b. Qualified Admission. For the purposes of this subsection (2), Qualified Admission shall mean a Base Period Claim excluding a claim:~~

~~i. Reimbursed under a per diem rate methodology; and~~

~~ii. For Delivery or Newborn Care.~~

~~c. Case Mix Adjustment. Each Qualifying Hospital will receive a payment equal to the product of:~~

~~i. The product of the hospital's:~~

~~A. number of Qualified Admissions; and~~

~~B. the CMAF; and~~

~~ii The sum of the hospital's:~~

~~A. rate for capital related costs in effect on July 1, 2000; and~~

~~B. the product of the hospital's CMI raised to the second power and the DRG PPS (Prospective Payment System) (see Chapter II) rate per discharge in effect on July 1, 2000.~~

~~3. DRG Adjustment - The Department shall make a DRG Adjustment to certain hospitals, as defined in this subsection (3).~~

~~a. Qualifying Hospital. A hospital that, during the Tertiary Adjustment Base Period, had at least one Qualified Admission shall qualify for this payment.~~

~~b. Qualified Admission. For the purposes of this subsection (3), Qualified Admission means a Base Period Claim, that was:~~

STATE OF ILLINOIS

METHODS AND STANDARDS FOR ESTABLISHING INPATIENT RATES FOR HOSPITAL REIMBURSEMENT: MEDICAL ASSISTANCE-GRANT (MAG). AND MEDICAL ASSISTANCE-NO GRANT (MANG).

~~i. Assigned by the Department to a DRG that:~~
~~A. had been assigned a weighting factor greater than 3.2000; and~~
~~B. for which fewer than 200 Base Period Claims were adjudicated by the Department; and~~
~~ii. Not a claim:~~
~~A. reimbursed under a per diem rate methodology;~~
~~b. for Delivery or Newborn Care; or~~
~~c. with a patient status code of 02 (patient transferred to another short term hospital).~~

~~c. DRG Adjustment rates. For each Qualified Admission, a Qualifying Hospital will receive a payment equal to the product of:~~
~~i. The hospital's DRG PPS rate per discharge in effect on July 1, 2000; and~~
~~ii. The weighting factor assigned to the DRG to which the Qualified Admission was assigned by the Department; and~~
~~iii. The constant 1.400.~~

~~4. Children's Hospital Adjustment - The Department shall make a Children's Hospital Adjustment to certain hospitals, as defined in this subsection (4).~~
~~a. Qualifying Hospitals. A children's hospital, as defined in Chapter II.C.3.a. , shall qualify for this payment.~~
~~b. Qualified Days. For the purposes of this subsection (4), Qualified Day means a day of care that was provided in a Base Period Claim, excluding a claim:~~

STATE OF ILLINOIS

METHODS AND STANDARDS FOR ESTABLISHING INPATIENT RATES FOR HOSPITAL REIMBURSEMENT: MEDICAL ASSISTANCE-GRANT (MAG). AND MEDICAL ASSISTANCE-NO GRANT (MANG).

~~i. For Delivery or Newborn Care;~~
~~ii. Assigned by the Department to a DRG with an assigned weighting factor that is less than 1.0000; or~~
~~iii. Billed to the Department under category of service 021 (hospital inpatient psychiatric services) or 022 (hospital inpatient physical rehabilitation services).~~

~~c. Children's Hospital Adjustment. A Qualifying Hospital shall receive a payment equal to the product of:~~
~~i. The sum Qualified Days from the hospital's Base Period Claims; and~~
~~ii. For hospitals with more than 5,000 Qualified Days, $670; or~~
~~iii. For hospitals with 5,000 or fewer Qualified Days, $300~~

~~5. Primary Care Adjustment - The Department shall make a Primary Care Adjustment to certain hospitals, as defined in this subsection (5).~~
~~a. Qualifying Hospital. A hospital located in Illinois that has at least one Qualifying Resident.~~
~~b. Qualifying Residents. The number of primary care residents, as reported on form HCFA 2552-96, Worksheet E-3, Part IV, line 1, column 1, for hospital fiscal years ending September 30, 1997, through September 29, 1998.~~
~~c. Qualified Admission. For the purposes of this subsection (5), Qualified Admission shall mean a Base Period Claim excluding a claim:~~
~~i. Billed to the Department under category of service 021 (hospital inpatient psychiatric services) or 022 (hospital inpatient physical~~

APR 05 2002

TN # 02-02 APPROVAL DATE _____ EFFECTIVE DATE 01-01-02
SUPERSEDES
TN # 01-20

STATE OF ILLINOIS

METHODS AND STANDARDS FOR ESTABLISHING INPATIENT RATES FOR HOSPITAL REIMBURSEMENT: MEDICAL ASSISTANCE-GRANT (MAG). AND MEDICAL ASSISTANCE-NO GRANT (MANG).

~~rehabilitation services) and reimbursed under a per diem rate methodology; and~~

~~ii. For Delivery or Newborn Care.~~

~~d. Primary Care Adjustment. A Qualifying Hospital will receive a payment equal to the product of:~~

~~i. The number of Qualifying Admissions during the Tertiary Adjustment Base Period;~~

~~ii. $4,675; and~~

~~iii. The quotient of:~~

~~a. the number Qualifying Residents;~~

~~b. divided by the number of Qualifying Admissions.~~

~~6. Long Term Stay Hospital Adjustment - The Department shall make a Long Term Stay Hospital Adjustment to certain hospitals, as defined in this subsection (6).~~

~~a. Qualifying Hospital. A long term stay hospital, as defined in Chapter II.C.4., that had a CMI that was greater than or equal to the mean CMI for all long term stay hospitals, shall qualify for this payment.~~

~~b. Qualified Days. For the purposes of this subsection (6), Qualified Day means a day of care that was provided in a Base Period Claim, excluding claims billed to the Department under category of service of 021 (hospital inpatient psychiatric services) or 022 (hospital inpatient physical rehabilitation services).~~

~~c. Long Term Stay Hospital Adjustment Rates. A Qualifying Hospital will receive payments equal to the product of:~~

~~i. The number of Qualified Days from all Base Period Claims; and~~

STATE OF ILLINOIS

METHODS AND STANDARDS FOR ESTABLISHING INPATIENT RATES FOR HOSPITAL ~~REIMBURSEMENT: MEDICAL ASSISTANCE-GRANT (MAG). AND MEDICAL ASSISTANCE-NO GRANT (MANG).~~

~~b. A constant that:~~
~~A. for a hospital that had a CMI that was greater than or equal to the mean CMI for all long term stay hospitals plus one standard deviation above the mean, $300; or~~
~~b. for a hospital that had a CMI that was greater than or equal to the mean CMI for all long term stay hospitals, but less than one standard deviation above that mean, $5.~~

~~7. Rehabilitation Hospital Adjustment - The Department shall make a Rehabilitation Hospital Adjustment to certain hospitals as defined in this subsection (7).~~
~~1. Qualifying Hospital. A hospital that qualifies for the Rehabilitation Hospital Adjustment under the Critical Hospital Adjustment Payments (CHAP) program, as defined in Chapter XV, shall qualify for this payment.~~
~~2. Qualified Admission. For the purposes of this subsection (7), Qualified Admission shall mean a Medicaid level I rehabilitation admission in the CHAP rate period, as defined in Chapter XV.B., for fiscal year 2001.~~
~~3. Rehabilitation Hospital Adjustment. A Qualifying Hospital shall receive payment as follows:~~
~~1. For a hospital that had fewer than 60 Qualified Admissions, $100,000.~~
~~2. For a hospital that had 60 or more Qualified Admissions, $350,000.~~

STATE OF ILLINOIS

METHODS AND STANDARDS FOR ESTABLISHING INPATIENT RATES FOR HOSPITAL REIMBURSEMENT: MEDICAL ASSISTANCE-GRANT (MAG). AND MEDICAL ASSISTANCE-NO GRANT (MANG).

8. ~~Tertiary Care Adjustment~~

~~1. The total annual adjustment to an eligible hospital shall be the sum of the adjustments for which the hospital qualifies under subsections (2) through (7) of this Section.~~

~~2. A total annual adjustment amount shall be paid to the hospital during the Tertiary Care Adjustment Rate Period in installments on, at least, a quarterly basis.~~

~~3. For fiscal year 2001 only, one-fourth of the total annual adjustment amount determined under this Section shall be paid during the fiscal year 2001 Tertiary Care Adjustment Rate Period.~~

STATE OF ILLINOIS

METHODS AND STANDARDS FOR ESTABLISHING INPATIENT RATES FOR HOSPITAL REIMBURSEMENT: MEDICAL ASSISTANCE-GRANT (MAG). AND MEDICAL ASSISTANCE-NO GRANT (MANG).

07/98 XX. Pediatric Inpatient Adjustment Payments

Pediatric Inpatient Adjustment Payments shall be made to all eligible hospitals excluding county-owned hospitals, as described in Section II.C.8, and hospitals organized under the University of Illinois Hospital Act, as described in Chapter II.C.8, for inpatient services occurring on or after July 1, 1998, in accordance with this Section. The provisions described in this Chapter will be effective through June 30, 2002.

A. To qualify for payments under this Chapter, a hospital must be a children's hospital, as defined in Chapter II.C.3, that was licensed by a municipality on or before December 31, 1997. Hospitals qualifying under this Section shall receive an adjustment for inpatient services equal to the product of the hospital's psychiatric and physical rehabilitation days, provided to children under 18 years of age during the adjustment base year, multiplied by $753 ~~$890~~ per day. Payments under this subsection will be based on the following methodology:

10/99 1. The calculation under subsection A. of this Chapter may not exceed 850 days.

10/99 2. For the purposes of calculating payments under this Chapter, the adjustment base year shall be psychiatric and physical rehabilitation days of care provided by the portion of the hospital that the Department does not recognize as a children's hospital. Such days include those provided in State fiscal year 1997 and adjudicated by the Department through March 31, 1998.

B. In addition to the payments described under subsection A. above, any children's hospital, as defined in II.C.3. will receive an additional adjustment equal to the product of the hospital's paid days, excluding Medicare crossover claims, multiplied by $104 ~~$123.50~~ per day. Such days include those provided in State fiscal year 1999 and adjudicated by the Department through May 31, 1999.

C. ~~For the rate year occurring in State fiscal year 2000, total payments made under subsection B. above will be made in three equal payments beginning with the quarter ending December 31, 1999.~~ For rate years occurring after State fiscal year 2000, total payments made under subsection A and B. above ~~will be made in four equal payments.~~ Shall be paid at least quarterly.

TN # 02-02
SUPERSEDES
TN # 99-09

APPROVAL DATE APR 05 2002 EFFECTIVE DATE 1-1-02

STATE OF ILLINOIS

METHODS AND STANDARDS FOR ESTABLISHING INPATIENT RATES FOR HOSPITAL REIMBURSEMENT: MEDICAL ASSISTANCE-GRANT (MAG). AND MEDICAL ASSISTANCE-NO GRANT (MANG).

D. For the remainder of the rate year occurring in State fiscal year 2002, total payments will equal the result of the following calculation:

1. The total payments resulting from payment methodologies in effect on January 1, 2002, will be reduced by the total payments calculated from the payment methodologies that were in effect on December 31, 2001.
2. The difference from subsection A(1) above will be divided by two and added to the total payments calculated from the payment methodologies that were in effect on December 31, 2001.
3. The result of the calculation in subsection A(2) above will be reduced by the actual payments each hospital already received for the period beginning July 1, 2001, and ending December 31, 2001, to produce the total payments for the remainder of State fiscal year 2002.